enabling people with disabilities	**SERVICE REQUEST FORM – ADULT**	**Please return to:** Ability West Access to Services Dept. Blackrock House Salthill Galway H91 R254 **Tel:** 091-540900

Prior to completion of this form please ensure that points 1 - 5 are adhered to;

1. The person resides within the catchment area of Ability West's Adult services.
2. The person has a diagnosis of an Intellectual Disability or an Intellectual Disability and Autism evidenced by a Psychological Assessment Report (to include cognitive and adaptive functioning).
3. All other relevant multi-disciplinary reports are available.
4. For adults transitioning from school to/from RT (Rehabilitative Training) and Adult Day Service placements in September, the form must be received by Ability West by December 15th of the previous year.
5. For general community Adult referrals, the form must be received at least 6 months before the expected commencement date for a service to allow for funding to be sought.

INDIVIDUAL INFORMATION

Name of Applicant:	**Date of Birth:**	**Age:**
Address:		
Gender:	**PPSN:**	
Name of Parent/Guardian 1:	**Date of Birth:**	
Address:		
Email:	**Telephone:**	
Name of Parent/Guardian 2:	**Date of Birth:**	
Address:		
Email:	**Telephone:**	

ADDITIONAL FAMILY MEMBERS

Name	Relationship to Adult	Date of Birth	School/Occupation	Receiving Support from other specialist services?

DETAILS OF APPLICATION (PLEASE TICK THE APPROPRIATE BOX)

Type of Application	Yes	No
A new application for a Community Adult Service from Ability West?	☐	☐
An application for a School Leaver/RT Transition?	☐	☐
An application for a transfer within Ability West Services?	☐	☐
Other (please specify):		

SUMMARY OF NEEDS (PLEASE TICK THE APPROPRIATE BOX)			
Mild Intellectual Disability:	☐	**Moderate Intellectual Disability:**	☐
Severe Intellectual Disability:	☐	**Severe & Profound Intellectual Disability:**	☐
Autism:	☐		
Please give details of the diagnosis and any additional disability/needs (e.g. Physical, Sensory, Medical):			
Details of Aids & Appliances used (if any):			
If the applicant a wheelchair user?			
If yes, what are the applicants transfer requirements?			

DETAILS OF RESIDENCE
Please give a brief outline of where the family live? (e.g. city, rural, distance from local town etc.)
Please provide directions to the family home from the nearest town:
Eircode:

MEDICAL INFORMATION		
Name of GP:	**Telephone:**	**Medical Card No:**

ALLOWANCES (PLEASE TICK THE APPROPRIATE BOX)		
Is the applicant/family member in receipt of the following	**Yes**	**No**
Is the applicant in receipt of Disability Allowance?	☐	☐
Does the applicant have access to their Disability Allowance?	☐	☐
Is a family member in receipt of Carers Allowance in respect of the applicant?	☐	☐

*** Ability West expects receipt of a contribution for overnight respite services and for full time living options. Ability West promotes the rights of all individuals which includes supporting adults to have full access to their own allowances/income ***

CURRENT SERVICE PROVISION	
Name of Agency:	**Day Service:**
Keyworker:	**Days per week:**
Support Level:	**Funding Allocated (if any): €**

CURRENT LIVING ARRANGEMENTS			
	Yes	**No**	**Name/Location**
Lives at home or with a family member:	☐	☐	
Supported Living (own apartment/home):	☐	☐	
Shared Living (full-time Home Sharing):	☐	☐	
Centre Based Residential Placement:	☐	☐	
Total Annual Cost of Residential/Full Time Living Service currently provided: €			
Is this funding transferable:			

DETAILS OF CURRENT MULTI-DISCIPLINARY INVOLVEMENT				
Multi-Disciplinary Service currently being availed of	**Yes**	**No**	**Name of Person Involved**	**Reports Available**
Psychology:	☐	☐		
Physiotherapy:	☐	☐		
Social Work:	☐	☐		
Speech & Language Therapy:	☐	☐		
Occupational Therapy:	☐	☐		
Positive Behaviour Support:	☐	☐		
Nurse:	☐	☐		
Psychiatry:	☐	☐		
Consultant (e.g. Neurology):	☐	☐		
Other:	☐	☐		

DETAILS OF CURRENT SHORT BREAKS RESPITE PROVISION				
Service Provision	**Yes**	**No**	**Name/Location**	**Frequency**
Community/Family Support:	☐	☐		
Home Sharing:	☐	☐		
Day Projects/Summer Projects/Social Groups:	☐	☐		
Centre Based Respite:	☐	☐		
Total Annual Cost of Current Respite Services Provided: €			**Is this funding transferable:**	

SERVICES REQUESTED (PLEASE IDENTIFY ONLY SERVICES AND SUPPORTS THAT ARE ASSESSED AS BEING REQUIRED)		
Day Service Type:	**Days per week:**	**Support Level:**

FUTURE NEEDS – FULL TIME LIVING OPTIONS		
To live in the family home or with a family member:	☐	☐
Supported Living (in own apartment/home):	☐	☐
Shared Living (full time Home Sharing)	☐	☐
Centre Based Residential Placement:	☐	☐

MULTI-DISCIPLINARY SERVICES REQUIRED	Yes	No	Reason
Psychology:	☐	☐	
Physiotherapy:	☐	☐	
Social Work:	☐	☐	
Speech & Language Therapy:	☐	☐	
Occupational Therapy:	☐	☐	
Positive Behaviour Support:	☐	☐	
Nurse:	☐	☐	
Psychiatry:	☐	☐	

SHORT BREAKS RESPITE SERVICES	Yes	No	Frequency	In Place (Y/N)
Community/Family Support:	☐	☐		**Yes ☐ / No ☐**
Home Sharing:	☐	☐		**Yes ☐ / No ☐**
Day Projects/Summer Projects/Social Groups:	☐	☐		**Yes ☐ / No ☐**
Centre Based Respite:	☐	☐		**Yes ☐ / No ☐**

ADULT APPLICANT/FAMILY INVOLVEMENT OF REFERRAL APPLICATION		
Has this Referral been discussed with the adult applicant?	**Yes ☐**	**No ☐**
Has this Referral been discussed with the family?	**Yes ☐**	**No ☐**
Have they consented to the sharing of their information?	**Yes ☐**	**No ☐**

REFERRER INFORMATION (MUST BE COMPLETED BY THE REFERRER)			
Name:	**Role:**		
Address:			
Telephone:	**Email:**		
I have reviewed the application form:		**Yes ☐**	**No ☐**
Psychological Report received:		**Yes ☐**	**No ☐**
Additional Multi-Disciplinary Reports available:		**Yes ☐**	**No ☐**
Costings and Budget Information provided:		**Yes ☐**	**No ☐**
Further Information added by Referrer:		**Yes ☐**	**No ☐**
Signature:		**Date:**	

FOR OFFICE USE ONLY				
Date Reviewed at Access to Services Meeting:				
Day Service Type:	**Days p/w:**		**Support Level:**	
Short Breaks Respite Services	**Yes**	**No**	**Frequency**	**Available (Y/N)**
Community/Family Support:	☐	☐		
Home Sharing:	☐	☐		
Day Projects/Summer Projects/Social Groups:	☐	☐		
Centre Based Respite:	☐	☐		
Multi-Disciplinary Services	**Yes**	**No**	**Available/Waitlisted/To be Referred**	
Psychology:	☐	☐		
Physiotherapy:	☐	☐		
Social Work:	☐	☐		
Speech & Language Therapy:	☐	☐		
Occupational Therapy:	☐	☐		
Positive Behaviour Support:	☐	☐		
Nurse:	☐	☐		

Full Time Living Option	Yes	No	Not Available
Supported in the family home:	☐	☐	☐
Supported Living (own apartment/home)	☐	☐	☐
Shared Living (full time Home Sharing)	☐	☐	☐
Centre Based Residential Placement	☐	☐	☐

FOR OFFICE USE ONLY (continued)			
Recommendations/Comments/Decisions (only roles marked * and services identified as required are necessary to sign off in the table below)			
Role	**Recommendation/Comments /Decision**	**Signature**	**Date**
*** Director of Client Services:**			
*** Assistant Director of Client Services:**			
*** Head of Social Work:**			
*** Head of Psychology:**			
Senior Occupational Therapist:			
Head of Physiotherapy:			
Behaviour Support Manager:			
Speech & Language Therapy Manager:			
Respite & Community Services Manager:			
Manager of Ancillary Services:			

FUNDING – CLIENT SERVICES DIRECTORATE			
Type of Service	**Staff WTE Required**	**Annual Funding Required:**	**Comments**
Adult Day Service:		**€**	
Home Sharing:		**€**	
Community Support:		**€**	
Centre Based Respite:		**€**	
Multi-Disciplinary Staffing:		**€**	
Aids & Appliances:	**N/A**	**€**	
Specific Training (e.g. PEG)		**€**	
Capital Costs:	**N/A**	**€**	
Transport:		**€**	
Escort for Transport:		**€**	
Business Case Required/Status:			
Proposed Commencement Date:			**Review Date:**

SENIOR MANAGEMENT TEAM			
Role	**Recommendation/Comments/Decision**	**Signature**	**Date**
Director of Client Services:			
Director of Finance:			
Director of Human Resources:			
Chief Executive:			
Date of Notification to the Board of Directors:			

REVISION		
Revision No:	**Date:**	**Description of Change**
1	24/08/2017	Revised/Updated Form